

September 18, 2020

Home Health Agency Provider Refresher Workshop 2020

Presented by:

**The Department of Social Services & DXC Technology
for Billing Providers**



Training Topics

- COVID-19 & 2020 Update
- Electronic Visit Verification (EVV) Program Update
- Provider Re-Enrollment
- Demographic Maintenance
- Eligibility
- Prior Authorization
- Claims Processing
- Medicare Cost Avoidance and Home Health Audit
- Claim Denial and Corrective Action
- Monthly Claims Reprocessing
- Remittance Advice (RA)
- Information/ Resources
- Contacts
- Questions/Comments

COVID-19 & 2020 Update

COVID-19 & 2020 Update

Telemedicine Services

Effective for dates of service **March 13, 2020 until the end of the temporary effective period**, the Department of Social Services (DSS) implemented medical and behavioral health services of specified synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner.

Telemedicine services are covered under the Connecticut Medical Assistance Program (CMAP) only when they:

- Are medically necessary,
- Are rendered via a HIPAA-compliant, real time audio and video communication system,
- Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face (in-person), including, but not limited to, enrollment, scope of practice, licensure, documentation, and other applicable requirements.

For reference, please see PB 2020-09 [New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program \(CMAP\)](#)

COVID-19 & 2020 Update

Telemedicine Services cont'd

What to know...?

- Reimbursement rates for telemedicine services are the same as for equivalent in-person services.
- Documentation must be maintained by the provider to substantiate the services provided.
- If a telehealth service cannot be provided or completed for any reason, such as due to technical difficulty, the provider shall not submit a claim for that service.

Modifiers

The following modifier(s) must be billed on services that are rendered via telemedicine.

- GT - used when the member's originating site is located in a healthcare facility or office.
- 95 - used when the member is located in the home.

COVID-19 & 2020 Update

Service Code Changes

Effective for **date of service March 27, 2020 and for the duration of the Temporary Effective Period**, the following non-waiver/waiver home health services may be rendered via synchronized telemedicine or telephonically (audio only).

- T1502 - Admin of oral intramuscular and/or subcutaneous medication, per visit
- T1503 - Admin of medication, other than oral and/or injectable, per visit

Please see provider bulletin PB 2020-28 [CMAP COVID-19 Response – Bulletin 13: Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services and Hospice](#)

for **date of service April 12, 2020 and for the duration of the Temporary Effective Period**, the following non-waiver/waiver home health services may be rendered via synchronized telemedicine.

- S9123 - Nursing Care in Home by Registered Nurse, per hour
- S9124 - Nursing Care in Home by Licensed Practical Nurse, per hour
- T1002 - RN services, up to 15 minutes
- T1003 - LPN/LVN services, up to 15 minutes

COVID-19 & 2020 Update

Service Code Changes cont'd

Effective for **date of service April 12, 2020 and for the duration of the Temporary Effective Period**, the following non-waiver/waiver home health services may be rendered via synchronized telemedicine.

- G0162 -Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes.
- G0151 -Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.
- G0152 -Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.
- G0153 -Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.
- 444 – Speech Pathology Evaluations for start of care and re-certification

Please see provider bulletin 2020-34 [CMAP COVID-19 Response – Bulletin 21: Select Added Services to the Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services](#)

COVID-19 & 2020 Update

Service Code Changes cont'd

Effective for **date of service March 27, 2020 and for the duration of the Temporary Effective Period**, the following non-waiver/waiver home health therapy services may be rendered via audio-visual telemedicine only.

421 - Physical Therapy 431 - Occupational Therapy 441 - Speech Pathology

These services may only be performed as a telemedicine service using a video communication system defined as real time audio and video synchronized telemedicine.

Audio-only telephone is not permitted for these services.

Please note: Initial evaluations and subsequent re-certifications for physical and occupational therapy must be performed **in-person** and are not eligible to be performed via telemedicine or telephonically.

For additional information, please refer to provider bulletin 2020-34 [CMAP COVID-19 Response – Bulletin 21: Select Added Services to the Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services](#)

COVID-19 & 2020 Update

Prior Authorization Changes

During the Temporary Effective Period, the following PA changes were made for home health services:

- PAs set to end in April and May 2020 were automatically extended for 90 days from the date the PA was set to end. PAs set to end in July 2020 have been extended out to October 2020.
- The PA thresholds for the following home health services were increased to minimize the need for home health agencies to request PA: Reference [PB 2020-33](#)
- **Nursing Services – PA will be required for skilled nursing in excess of the initial evaluation and five (5) visits per week**
 - Pregnancy-related preventive prenatal nursing care services in excess of **five (5) visits during the prenatal period**
 - Pregnancy-related preventive postpartum nursing care services in excess of **five (5) visits during the postpartum period**
 - Physical therapy services in excess of the **initial evaluation and four (4) visits per week**
 - Speech therapy services in excess of the **initial evaluation and four (4) visits per week**
 - Occupational therapy in excess of the **initial evaluation and two (2) visits per week**

COVID-19 & 2020 Update

Behavioral Health Prior Authorization Changes

Effective **April 1, 2019 and forward**, all home health services for clients with CHC, PCA, ABI, and Autism waivers with a **behavioral health** primary diagnosis code will no longer receive PA from Beacon Health Options.

Prior Authorization Search

Client ID: 00000000

Client Name: Waiver, Betty

Search Pharmac Pkg only:

Requested Off Date:

Requested End Date:

Authorized Off Date:

Authorized End Date:

Prior Authorization:

PA Assignment: AUTISM

PA Assign - Sub: B

Procedure: [Search]

Revenue Code: [Search]

ProcMed List:

Procedure Code List: [Search]

Records: 20

What to Know...?

- PA will be provided by DSS' Community Options Unit or the Access Agency responsible for the clients care plan
- A new **PA Assign-Sub value "B"** was created which helps providers easily determine Behavioral Health from non-Behavioral Health PAs
- MFP clients will continue to be identified by the PA Assign-Sub value of "M".

Please refer to provider bulletin 19-13 [Changes to Behavioral Health Prior Authorization Requests for Home Health Services to Waiver Clients](#)

COVID-19 & 2020 Update

SOC & ROC Modifier Changes

Effective for dates of service **August 1, 2019 and forward**, when billing for start of care evaluations/assessments (SOC), resumption of care evaluations (ROC) and 60-day recertification reviews, the following modifiers are **not** required:

- TT-Individualized services provided to more than one patient in the same setting;
- TG-Complex/high level of care.

Please refer to provider bulletin 19-49 [Correction to the Guidance for Billing Evaluation and Assessment Services for Home Health Care Services](#)

Electronic Visit Verification (EVV) Program Update



Electronic Visit Verification (EVV) Program Update

Overview

Electronic Visit Verification (EVV) is the system that Home Health providers who service Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) or Personal Care Assistance (PCA) waiver clients must use to schedule visits, capture visit times and maintain visit data used to verify claims data submitted to DXC Technology for adjudication. The EVV system has been specifically configured to support the Department of Social Services (DSS) program requirements.

EVV was implemented for Home Health providers effective April 3, 2017. EVV is federally mandated for Home Health providers effective January 1, 2023.

Providers who choose not to use EVV as directed will experience claim denials for services that are mandated for EVV use.

Electronic Visit Verification (EVV) Program Update

Service Code Changes

During the **Temporary Effective Period**, the following service codes are temporarily suspended in EVV:

- S9123 – Nursing Care in Home by Registered Nurse, by hour
- S9124 – Nursing Care in Home by Licensed Practical Nurse, per hour
- T1002 – RN Services, up to 15 minutes
- T1003 – LPN/LVN services, up to 15 minutes
- T1502 - Medication administration visit
- T1503 - Medication administration, not oral/injection
- G0151 – Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
- G0152 – Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
- G0153 – Services performed by a qualified speech language therapist in the Home Health or Hospice setting, each 15 minutes.

Electronic Visit Verification (EVV) Program Update

Service Code Changes cont'd

- G0162 – Skilled services by a registered nurse, (RN) for management and evaluation of a plan of care.

As a result, providers will see PAs for these services in their Santrax system but:

- Providers do not have to use EVV to capture visit data or submit claims
- A confirmed visit is not required to bill and get paid for services performed
- The following explanation of benefit codes (EOBs) will not set on claims for the aforementioned services:
 - 3327 – Confirmed Visit Not Found,
 - 3328 – Confirmed Visit Units are Exhausted
 - 0047 – Confirmed Visits Units are Exceeded

For additional information, please refer to provider bulletin: [PB 20-34 - CMAP COVID-19 Response – Bulletin 21: Select Added Services to the Emergency Temporary Telemedicine Coverage/Telephonic Coverage for Specified Home Health Services](#)

Electronic Visit Verification (EVV) Program Update

Service Code Changes cont'd

During the temporary effective period, the following Revenue Center Codes (RCC) will **not** be present in the Santrax system and these services are suspended from EVV. PAs for these services will continue to be visible via the secure web provider portal and providers will have to bill outside of EVV for these services.

- 421 – Physical Therapy, Per Diem
- 431 – Occupational Therapy, Per Diem
- 441 – Speech Therapy, Per Diem
- 444 – Speech Therapy Evaluation for the Start of Care (SOC)/ Resumption of Care (ROC)

For additional information please refer to [“Changes to EVV Optional Service Code Listing” Important Message](#)



Electronic Visit Verification (EVV) Program Update

Suspension of EVV Compliance Requirement

In response to the outbreak of COVID-19, DSS temporarily lifted the EVV 90% compliance requirement. Providers will not be held accountable for being less than 90% compliant until further notice.

DSS considers a provider to be compliant if 90% of the visits performed are *validated by a check-in and a check-out documented by the caregiver via telephony, Mobile Visit Verification (MVV) or Fixed Visit Verification (FVV) device*. Providers who fail to reach this 90% threshold may be subject to audit, suspension of referrals or claim recoupments until the provider becomes compliant.

For more information regarding compliance, please see [At Your Fingertip tip sheet #4 – Compliance, “Important EVV Compliance Clarifications”](#) Important Message and Provider Bulletin [19-17 Electronic Visit Verification \(EVV\) – Compliance Requirement Update](#).

Electronic Visit Verification (EVV) Program Update

Sandata Mobile Connect (SMC)

Effective August 3, 2020, the Mobile Visit Verification (MVV) app was upgraded to the Sandata Mobile Connect (SMC) app. All EVV service providers are able to transition their MVV users to the SMC app so that they can take advantage of SMC's many benefits.

Please note: On October 1, 2020, the Mobile Visit Verification (MVV) app will be deactivated and cannot be used to capture visit data for EVV. On October 1, 2020, **all** mobile app users must use SMC to capture visit data on their smart phone.

What are the benefits of SMC?

- Caregivers can reset their own passwords.
- Caregivers can see previously scheduled and upcoming visits in the SMC app.
- Caregivers can create call values for Blended Services.

For additional information, please refer to [**“Introducing the Sandata Mobile Connect \(SMC\) App”**](#) Important Message.

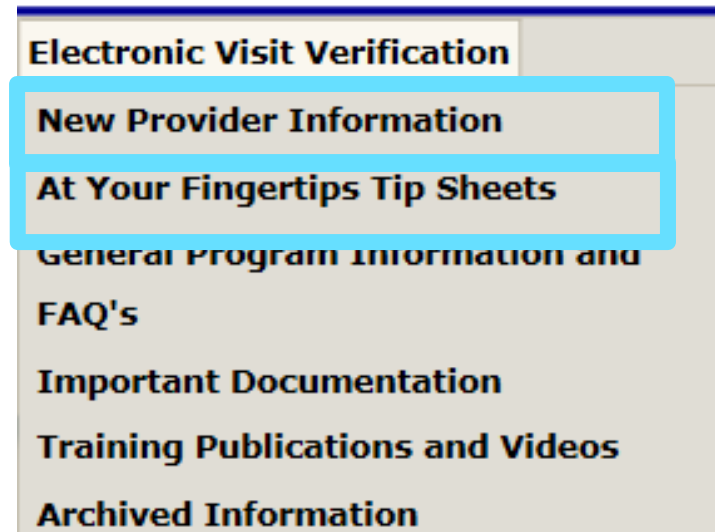
Electronic Visit Verification (EVV) Program Update

EVV Webpage

As of May 8, 2019, the Electronic Visit Verification Implementation Important Message was replaced with the EVV Web page. The EVV Web page organizes EVV information and makes it easier to access and review EVV information.

New Provider Information – This page familiarizes new providers and new office staff with the Sandata system and EVV. Resources on this page include instructions on how to access the Welcome Kit, Frequently Asked Questions and Who to Contact for Assistance.

At Your Fingertips Tip Sheets – This page contains the At Your Fingertips tip sheets which answer common questions and helps resolve common EVV issues.

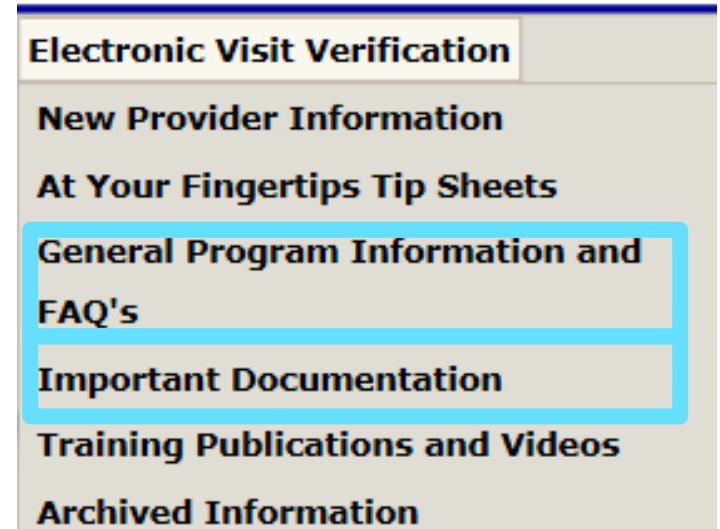


Electronic Visit Verification (EVV) Program Update

EVV Webpage

General Program Information and Frequently Asked Questions – This page houses the EVV Service Code Listing, the finalized Reason Code List and the finalized Task List

Important Documentation – This page contains all EVV related important messages, provider bulletins, important notices and other important notifications to assist providers in their use of EVV. This page also has the Who to Contact for Assistance document.




Electronic Visit Verification
New Provider Information
At Your Fingertips Tip Sheets
General Program Information and FAQ's
Important Documentation
Training Publications and Videos
Archived Information

Electronic Visit Verification (EVV) Program Update

EVV Webpage

Training Publications and Videos – This page provides links to the Learning Management System for providers who need to complete the mandatory training or want to refresh themselves on the EVV system. It also contains specific training documentation on Sandata Mobile Connect (SMC) and Fixed Visit Verification (FVV) device.

Archived Information – This page contains outdated documents that should not be referred to in the current use in the EVV system. They are being retained for historical reasons only.



Electronic Visit Verification
New Provider Information
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Archived Information



Electronic Visit Verification (EVV) Program Update

Alternate Claim Solution

Effective April 11, 2018, DSS implemented the alternate claim solution which allows providers to bill or adjust claims for dates of service on or after January 1, 2018 from:

- their own system,
- via the www.ctdssmap.com secure Web site,
- from the Santrax system
or
- any combination of these three methods.

For a claim to pay as expected, the visit(s) must be OK to bill in Santrax, confirmed in Santrax, the client must be eligible on their EVV mandated waiver and the client must have a prior authorization (PA) for the services performed. If the visit submitted for payment outside of Santrax does not agree with a visit in Santrax, the visit will deny payment.

Electronic Visit Verification (EVV) Program Update

Alternate Claim Solution

To remember:

- The alternate claim solution does not remove the requirement that providers use the Santrax system to create schedules, check-in/out or confirm visits.
- The alternate claim solution does not change the EVV compliance requirement; providers are still expected to achieve a minimum 90% compliance rate in their use of the EVV system.
- If you choose to export your claims **OUTSIDE** of Santrax, claim export requirements within Santrax will no longer need to be maintained, such as the skilled services requirement to capture physician signature, or identify third party liability (TPL) or diagnosis codes.
- Claims exported outside of Santrax must match a confirmed visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

For more information, see Provider Bulletin 18-17 “[Electronic Visit Verification \(EVV\) Enhancement – Alternate Claim Solution](#)” and [At Your Fingertip tip sheet #16 – Alternate Claim Solution Explanation of Benefits](#).



Electronic Visit Verification (EVV) Program Update

Temporary Client

For a client to be present in your Santrax system, the client must:

1. **be active on their EVV mandated waiver**
2. **have an approved PA assigned** to your agency on the CMAP Web site

There may be times when there is delay from when a client is referred to your agency and the client is present in the Santrax system. This delay does not prevent your agency in creating a schedule in Santrax or for the caregiver to capture visit data.

To learn more, please navigate to www.ctdssmap.com > Electronic Visit Verification > Training Publication and Videos > Job Aids then select “Temporary Client – Merging Process” and “Temporary Client – Checklist”.



Electronic Visit Verification (EVV) Program Update

Temporary Client

The Temporary Client Enhancement allows office staff to schedule visits and resolve visit exceptions for clients who are not yet present in Santrax via the automatic upload. It also allows the client's caregiver to utilize all the check-in and check-out features available while they wait for the permanent client record to be uploaded to the Santrax system.

If your agency thinks a client's permanent record should be in Santrax, first **verify that the client is active on their EVV mandated waiver and has a PA in an approved status on the CMAP secure Web site**. If the client is active on their waiver and has an approved PA and the client is not present in Santrax, please contact Sandata Customer Care for assistance in displaying the client.

For more information about the Temporary Client Enhancement, navigate to the Electronic Visit Verification Web page > Training Publications and Videos > Job Aids > Temporary Client - Merging Process

Electronic Visit Verification (EVV) Program Update

Client Eligibility

Client Eligibility must be verified prior to providing services to avoid claim denials because of ineligibility

- A client present in the EVV system does not automatically mean they are eligible for the services provided.
- Prior Authorization does not guarantee that the client is eligible for the services to be provided.
- Eligibility can change at any time.

If a client is ineligible on their EVV mandated waiver benefit plan:

- A check-in/check-out can still occur.
- Using the temporary client feature the visit can be scheduled and, when completed, confirmed in Santrax
- The care manager at the access agency responsible for the clients care plan should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible.
- The visit **CANNOT** be exported or uploaded to DXC for claim adjudication

Electronic Visit Verification (EVV) Program Update

Client Eligibility continued

Providers who identify an eligibility issue that has not been resolved after some time should **first contact the access agency in charge of the client's care plan for assistance**. The provider should check with the care manager to see if the **Medicaid redetermination and required financial verifications** have been submitted. If the redetermination and required documentation have been received and the access agency is unable to render assistance, the provider should send an encrypted email to Waiver.DSS@ct.gov.

The email should include:

- The client's name, client ID and the date service began or is scheduled to begin.

- Place the words "Autism, ABI, CHC or PCA Waiver Client Eligibility Issue" in the subject line of the email.

Electronic Visit Verification (EVV) Program Update

Prior Authorization

Access agencies (CHC and PCA Waiver clients) and Case Management agencies (Autism and ABI Waiver clients):

- Are required to upload a care plan to DXC Technology within seven (7) business days from initiating a service order.
- Both new and changed service authorizations uploaded to DXC Technology will be automatically sent daily to the EVV system, to ensure the EVV system is up to date.

If a visit occurs prior to the prior authorization being in the DSS portal:

- Caregiver can still complete the check-in and check-out procedure in Santrax.
- Using the temporary client enhancement, a schedule can be created and the visit confirmed.
- Once the PA has been uploaded to Santrax and the temporary client merged with the client record, the claim can then be submitted to DXC Technology for claims processing.

Note: Prior authorizations must be able to be viewed in the DSS secure site in order to be able be viewed in Santrax. If you cannot view a PA in the DSS secure site, the PA has not been uploaded. Please contact the access agency responsible for the client's care plan for assistance.

Electronic Visit Verification (EVV) Program Update

Missing Client/ Prior Authorization

If you are missing a client or prior authorization (PA) in the Santrax system:

- Confirm the client is eligible on an EVV mandated waiver by researching the client's eligibility on the DSS Web portal (www.ctdssmap.com)

and

- Confirm the client has an approved PA assigned to your agency by viewing the prior authorization on the DSS Web portal (www.ctdssmap.com)

If, after you confirm the client is eligible on their waiver benefit plan and has a PA assigned to your agency, the client is not present in your Santrax system, please send an email to the EVV mailbox, ctevv@dxc.com, and provide the PA number (as displayed on the DSS secure site www.ctdssmap.com) and the eligibility verification number. Someone will research the issue and provide any next steps.

Please note: if the client does not have a PA number on the CMAP portal, please follow up with the access agency responsible for the client's care plan.

Electronic Visit Verification (EVV) Program Update

- ❑ If you are **missing a client** from your Santrax system and have verified that the client is active on their EVV mandated waiver *and* has an active PA on the CMAP portal, please send a **secure** email to ctevv@dxc.com. **If you are unable to send encrypted emails, please just send a PA for that client to the ctevv@dxc.com mailbox.**
- ❑ If a **prior authorization** (PA) is present on the DSS secure site but is not present in Santrax 48 hours after upload to the CMAP secure site, please send an email to ctevv@dxc.com and provide the PA number, as it is displayed on the CMAP secure site.
- ❑ If you are experiencing **issues with the Santrax system** and its functionality, please contact Sandata Customer Care. They can be reached at 1-855-399-8050 or by email at ctcustomer@sandata.com.

If you are unsure who to contact for assistance, please send an e-mail to ctevv@dxc.com. You are also encouraged to send an e-mail to the ctevv@dxc.com mailbox if you feel you need additional support resolving your issue.

Important: Do not email client identifying data unless you encrypt your e-mail.

Provider Re-enrollment

Provider Enrollment and Re-enrollment

The Department of Social Services (DSS) requires providers to enroll / re-enroll on our Web site www.ctdssmap.com.

- ❑ A majority of the required information on a re-enrollment application is automatically populated based on the provider's previous contract information.
- ❑ Online re-enrollment cannot be initialized until an ***Application Tracking Number (ATN)*** is received from the DXC Technology Provider Enrollment Unit.
- ❑ Re-enrollment Period: Home Health providers are required to **re-enroll every 2 years.**



Provider Enrollment and Re-enrollment

Re-enrollment Notification and Process:

- ❑ Home Health providers will receive a reminder letter via eDelivery when they are due for re-enrollment **six (6) months** prior to the end of their current contract (Reference www.ctdssmap.com > Information > Publications > Provider Newsletters > August 2020 > Important Re-Enrollment Information)

It is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice.

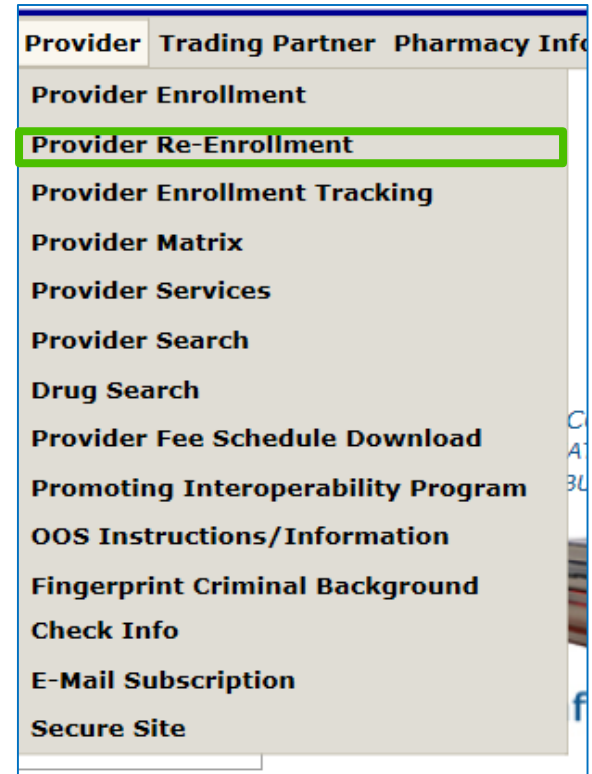
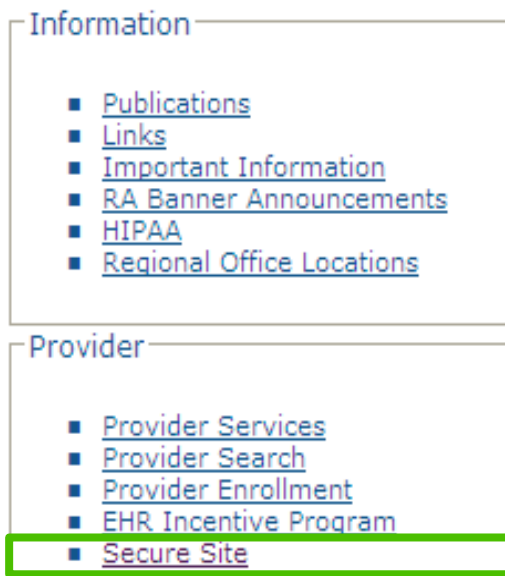
Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.

- ❑ Providers who are dis-enrolled *will not be able to bill or receive payment* for services rendered until re-enrollment is completed.
- ❑ Reinstatement of contracts w/out a finalized application violates ACA policies.

Provider Enrollment and Re-enrollment

Re-enrollment via the Enrollment/Re-enrollment Wizard on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com, is required.

Select *Provider Re-Enrollment* from the *Provider* drop-down menu.



Provider Enrollment and Re-enrollment

Follow on Documents:

- ❑ Once the enrollment/re-enrollment application is submitted, providers are notified of any follow-on documents that need to be mailed to DXC Technology's Enrollment Unit. The follow-on documents can also be found on the Web site (www.ctdssmap.com) by selecting Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty.
- ❑ The document requirements vary by provider type. The enrollment/re-enrollment application is not considered complete until **all** the required documents have been received.

The screenshot shows the DXC Technology website interface. The top navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, and Electronic Visit Verification. The 'Provider' dropdown menu is open, listing various services such as Provider Enrollment, Re-Enrollment, Tracking, Matrix, Services, Search, Drug Search, Fee Schedule Download, and the Interoperability Program. The 'Provider Matrix' section is highlighted, and a green arrow points to the link 'Follow on Document Requirement by Provider Type and Specialty'.



Provider Enrollment and Re-enrollment

Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.

Providers who are dis-enrolled will not be able to do the following until re-enrollment is completed:

- Get new referrals to services
- Receive Prior Authorization
- Bill or receive payment for services rendered.

Reinstatement of contracts w/out a finalized application violates ACA policies

Provider Enrollment and Re-enrollment

Re-enrollment Due Dates:

Providers with Secure Web portal access can view their re-enrollment due date once logged in.

- Providers can view their re-enrollment due date on the Home page.
- This feature allows agencies to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Claims Eligibility Prior Authorization Hospice Trade Files MAPIR Messages Account

home **account home** account maintenance account setup change password clerk maintenance demographic maintenance reset password log out

Welcome, P0042

Provider ID: NPI

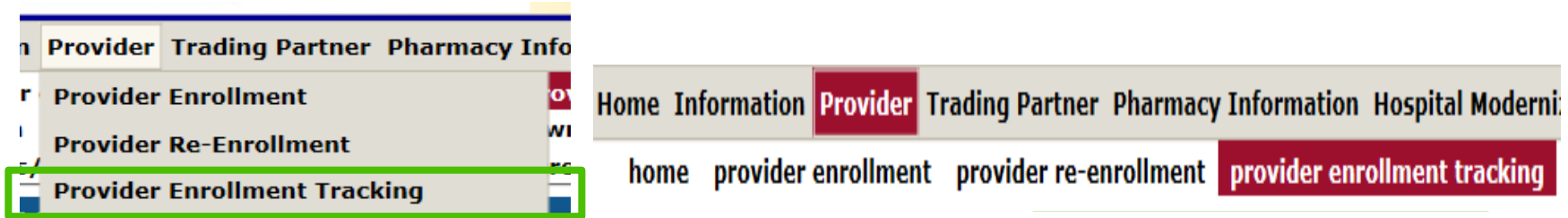
Provider AVRS ID:

Reenrollment Due Date: **10/28/2020**

Zip Code: 06010 - 5106

Provider Enrollment and Re-enrollment

To check the status of a re-enrollment application, select *Provider Enrollment Tracking* from either the *Provider* submenu or the *Provider* drop-down menu.



Enter your *ATN* and *Business OR Last Name as enrolled* and click *search*

Enrollment Tracking Search

ATN*

Business OR Last Name*

☐ In this example DSS is reviewing the application that was submitted on June 13, 2019.

Search Results	
Date Received	Status
06/13/2019	DSS Conducting Initial Review

Demographic Maintenance

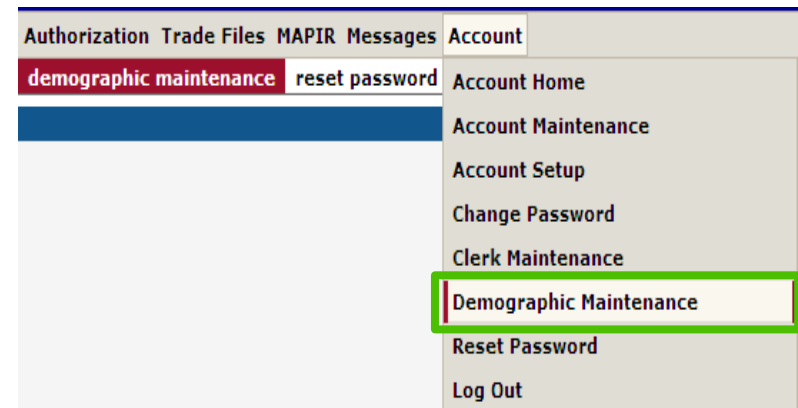
Demographic Maintenance

DSS requires providers to update their demographic information via their secure Web account. Demographic information includes provider addresses, languages known by staff, Electronic Funds Transfer (EFT) and member of organization maintenance. Failure to update demographic information could result in the delay of receipt of time sensitive information, information being sent to the wrong address, or delay of payments.

You can alter and update demographic information in the Demographic Maintenance section of the Secure Site :

- All address types including Mail to, Pay to, Service Location, and Enrollment and Home Office addresses
- EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)
- Maintain Organization Members

Access this section by selecting demographic maintenance from either the Account submenu or the Account drop-down menu.



Demographic Maintenance

The Demographic Maintenance page displays the provider information panel as well as a submenu.

Clicking the submenu options will open a panel with related information:

- Base Information
- Service Location
- Location Name Address
- EFT Account
- Service Language

Provider Information			
Provider ID	1234567890	Address	15 Main Street
Organization	Sole Proprietor		Suite 2A
Usage	Service Location	City	Willimantic
Provider Type	27 - Dentist	County	Fairfield
Ownership	Yes	State/Zip	CT 06614-4008
Phone	203-555-5555		

[Base Information](#) > [Service Location](#) > [Location Name Address](#) > [EFT Account](#) > [Service Language](#) > [Maintain Organization Members](#)

Demographic Maintenance – Location Name Address

Specify different mailing, payment, service location, enrollment and Home Office addresses, if applicable.

Location Name Address

- If a provider is moving its office location, that change in address can be made via this panel. If the provider is a licensed facility (such as a clinic, hospital or pharmacy) moving to a different location but still using the same license, this requires that you submit an updated copy of your license after the address update has been completed. The copy of the license should be mailed to DXC Technology Provider Enrollment, P.O. Box 5007, Hartford, CT 06102-5007, with a note that the address update has been made via the Web portal and the provider is sending a copy of their license to retain with their enrollment/re-enrollment records.

Warning - PCMH and Glide Path Providers ONLY

If you are a PCMH or Glide Path provider, a change to your address information for an existing PCMH/Glide Path site may affect your claim payments. To ensure your practice receives the fee differential payments for primary care services, your primary and/or alternate service location address submitted on claims MUST match exactly to the primary and/or service location address indicated here. Any type of address change made via this Web portal, whether it be as simple as adding a suite number or a total overlay of an address due to the move of an office, must also be communicated back to CHN using CHN's Change Request Form. This form is located at www.huskyhealthct.org, by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the PCMH and Glide Path Change Request Form. If there are claims to be processed for the address you are updating, please do not initiate that address update via this Web portal application. Rather, submit the request to update the address in writing to DXC Technology Provider Enrollment Unit at PO Box 5007, Hartford, CT, 06102-5007. Any updates to address information via the Web portal, when there are still claims to be processed for that address, may cause the fee differential payment not to be applied to those claims.

Usage	Name	Address 1	City	State	Zip	Zip + 4	Contact Phone	Contact Ext	Handicap Access	Address Indicator
Enrollment Address	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Mail to	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Pay to	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Service Location	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V

Type changes below.

maintain address

Name Type Business Name Personal Name

Apply Changes To:

Svc Loc

Pay To

Mail To

Enrollment

Name

Title

Usage

Country

Address 1

Address 2

City

State

Zip

Contact Name

Contact Phone

Fax

Email

Confirm EMail

Address Indicator

Handicap Accessible?

Demographic Maintenance – Location Name Address

To update address information, simply select the applicable row from the provided list (Alternate Service Location, Enrollment Address, Home Office, Mail to, Pay to, or Service Location); then click ‘maintain address’

Provider Location Name Address											
Usage	Name	Street	City	State	Country	Zip	Zip + 4	Contact Phone	Contact Ext	Handicap Access	Address Indicator
Alt Service Location	HARPER, KATHLEEN	1275 POST ROAD	FAIRFIELD	CT		06824	6015			N	V
Alt Service Location	HARPER, KATHLEEN	1020 MEMORY LN	HARTFORD	CT	US	06066	6066	(860)741-2333		N	V
Alt Service Location	HARPER, KATHLEEN	1020 MEMORY LN	HARTFORD	CT	US	06066	6066	(860)741-2333		N	V
Enrollment Address	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT	US	06824	5166	(203)254-2452		N	V
Home Office	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V
Mail to	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V
Pay to	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V
Service Location	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V

maintain address

Select/fill in the appropriate information (address, phone number, etc.): click ‘save’

The following messages were generated:

Message Description	Panel	Field
Save was Successful		

Web Account Capabilities

The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited.

** If you change bank accounts, your EFT Account information should be updated to prevent deposit discrepancies.**

The screenshot shows a web form titled "EFT Account" with a sub-header "Click here to open Provider EFT Enrollment instructions." The form contains a table with the following data:

Financial Institution Name	Financial Institution Routing Number	Provider's Account Number with Financial Institution	Type of Account at Financial Institution	Last Change Date	EFT Status
TD BANK NA	011100111	4242042420	Checking		Active

Below the table, there are several sections of input fields:

- Required fields are indicated with an asterisk (**)**
- Provider Name*** (text input)
- Account Number Linkage to Provider Identifier*** (text input)
- Provider Tax Identification Number (TIN)** (text input)
- OR**
- National Provider Identifier (NPI)** (text input)
- Reason for Submission** (radio buttons): New Enrollment, Change Enrollment, Cancel Enrollment
- Authorized Signature** (text input)
- Other Identifiers** (text input)
- Assigning Authority** (text input)
- Trading Partner ID** (text input)
- Financial Institution Information** (text input)
- Financial Institution Address** (text input)
- Street** (text input)
- City** (text input)
- State/Province** (text input)
- ZIP Code/Postal Code** (text input)
- Financial Institution Routing Number** (text input)
- Financial Institution Routing Number(rekey)*** (text input)
- Type of Account at Financial Institution** (dropdown menu)
- Provider's Account Number with Financial Institution** (text input)
- Provider's Account Number with Financial Institution(rekey)*** (text input)

At the bottom right, there are "save" and "cancel" buttons.

Click 'add'; enter the appropriate information, and click 'save'

When EFT information is updated, you will receive a confirmation letter via E-Delivery notifying your agency of the change.

Eligibility

Eligibility - Verification

To check a client's eligibility, log into the DSS secure Web portal.

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernization

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services
oos instructions/information fingerprint criminal background check info e-mail subscription **secure site**

Login

The Connecticut Department of Social Services Medical Assistance Program secure website is intended for providers, clerks and billing agents.

If you have received your Personal Identification Number letter, click on the setup account button.

[setup account](#)

User ID*

Password*

[login](#)

Eligibility - Verification

To check a client's eligibility, log into the DSS secure Web portal. Click on the "Eligibility" menu

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification Claims Eligibility Prior Authorization

home **account home** account maintenance account setup change password reset password log out

Your password expires in 14 day(s) on 9/11/2020 at 12:00 AM [Change Password](#)

Welcome **HOME HEALTH AGENCY**

Reenrollment Due Date: | **11/25/2020**

Eligibility - Verification

Receipt of a service order from the Case Management/ Access Agency confirms the client is eligible on their appropriate waiver. However, the client's eligibility file may not yet reflect the client's current waiver eligibility. To avoid unnecessary claim denials such as:

- EOB code 2003 - The client was not eligible on the date of service
- EOB code 4021 - The service provided was not a covered service under the client's benefit plan

It is recommended that providers verify client eligibility upon receipt of the initial service order, at the resumption of care, at a change in the plan of care and at regular intervals.

Eligibility verification can be performed in the following ways:

- Internet Web site at www.ctdssmap.com.
- Automated Voice Response System (AVRS).
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.
- Provider Electronic Solutions (PES) software.

Eligibility - Verification

To verify a CMAP client's eligibility through the secure site – click on the *Eligibility* tab on the main menu.

Home Information Provider Trading Partner ConnPACE Pharmacy Information Claims **Eligibility** Prior Authorization Trade Files MAPIR Messages Account

Enter enough data to satisfy at least one of the *valid search combinations*; click *search*

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Claims **Eligibility** Prior Authorization Hospice MAPIR Account ConnPACE

Valid Search Combinations

- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date

Enter data to satisfy at least one of the valid search combinations; click search.

When entering a full name as part of your search criteria, a middle initial is required if present in the client's "CMAP profile."

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text" value="Doe"/>	From DOS*	<input type="text" value="01/01/2018"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="John"/> <input type="text"/>	To DOS*	<input type="text" value="01/31/2018"/>
Birth Date	<input type="text" value="02/05/1955"/>				
Service Type Code 1	<input type="text" value="30 - Health Benefit Plan Coverage"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

Eligibility - Verification

Positive eligibility responses provide greater detail.

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text" value="DOE"/>	From DOS*	<input type="text" value="05/01/2018"/>
SSN	<input type="text" value="666-55-4444"/>	First Name, MI	<input type="text" value="JOHN"/> <input type="text"/>	To DOS*	<input type="text" value="05/30/2018"/>
Birth Date	<input type="text"/>				
Service Type Code 1	<input type="text" value="54 - Long Term Care"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

Eligibility Verification Response

Verification Number	<input type="text" value="15040039KM"/>
Response Text	<input type="text" value="Client is eligible. Refer to Benefit Plan for specific program coverage."/>

Eligibility - Verification

What does all this information *mean*?

Eligibility Verification Response - Provides a verification number that should be kept on record in case the client's coverage is retroactively changed at a later date. Provides proof you researched the clients eligibility and verified coverage at the time of service.

Reports client's eligibility status for the requested date(s) of service

Eligibility Verification Response	
Verification Number	1120900015
Response Text	Client is eligible. Refer to Benefit Plan for specific program coverage.

Client Information

THOMAS

Client Information			
Client ID	009999999	Last Name	THOMAS
SSN	111-99-9999	First Name, MI	
Birth Date	01/20/1997	Street	1 MAIN ST
Gender	M	City, State, Zip	TORRINGTON, CT 06790

Eligibility – Verification

Benefit Plan

The benefit plan(s) with which the client was an active member on the date(s) of service requested

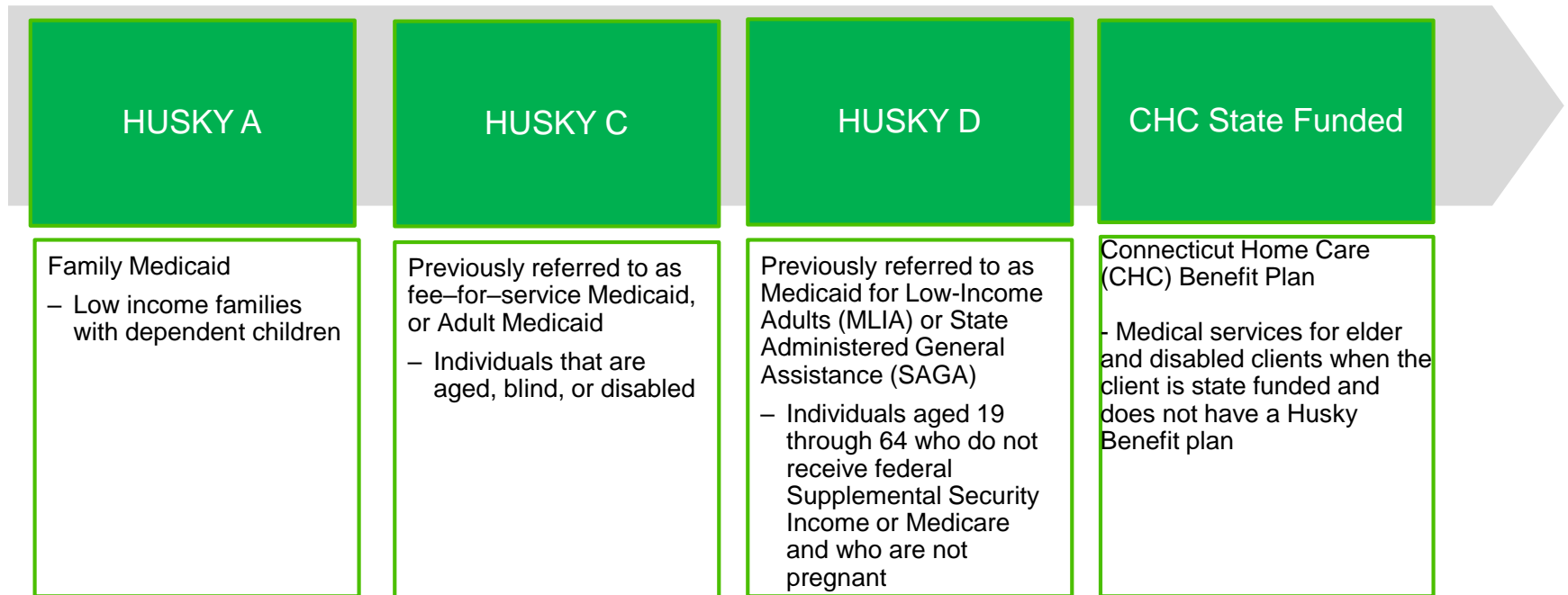
- A client having an Autism, ABI I or ABI II Waiver, PCA or CHC benefit plan requires all Home Health services to be in the Care plan in order for the Home Health provider to be reimbursed for services provided.
- The client must also have a HUSKY A, C or D benefit plan for Home Health services to be paid, **unless a client has a CT Home Care State Funded benefit plan only.**

Benefit Plan				
Service Information ^A	Benefit Month Effective Date	Effective Date	End Date	Message
ABI II Acquired Brain Injury	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

Eligibility Verification

Web Account Capabilities

Benefit Plans payable for Home Health Services



Prior Authorization

Prior Authorization

Care Plan Access – PA Search

Once on the secure site, click [Prior Authorization](#) > [Prior Authorization Search](#).

The screenshot shows a web application interface. At the top, there is a navigation bar with the following links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, Hospice, MAPIR, and Account. Below this bar is a secondary navigation bar with links: home, account home, account maintenance, account setup, change password, reset password, and log out. A dropdown menu is open under the 'Prior Authorization' link, containing the following options: Prior Authorization Search (highlighted with a green box), Care Plan, and Pharmacy Prior Authorization. A separate button labeled 'Prior Authorization Search' is also visible to the right of the dropdown. Below the navigation bars, the text 'Welcome, Home Health Agency' is displayed. At the bottom left, the text 'Reenrollment Due Date: 10/29/2020' is shown.

Prior Authorization

Prior Authorization Search

It is easier to search by Client ID or PA Number, however you can search by any combination of the fields below, such as by date, procedure or list code.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Claims Eligibility **Prior Authorization** Hospice Trade Files MAPIR Messages Account

home **prior authorization search** care plan pharmacy prior authorization

Quick Link

- Web Guide - Prior Authorization Search

Provider 001234567 MCD

Prior Authorization Search

Client ID

Client Name

Search Pharmacy PAs only

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assign - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Procedure Code List [Search]

Records

Prior Authorization

PA Search Results

The search results by client shows multiple PAs and services authorized.

Search results can include PAs authorized by procedure code, procedure code with modifier, procedure code lists and proc/mod lists.

For ease in viewing, data can be sorted by clicking on the desired sort field, until a triangle appears. Click on the triangle to sort in ascending or descending order.

» Search Results													
PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub	Prescribing/Ordering Provider ID	Service Code	Service Code Thru	Proc/Mod List	Frequency	Status
0771009324	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial	NPI			SN	36 Per Date Span	Auto Approved for Care Plan
0771009325	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial	NPI	T1004			8 Per Calendar Week	Auto Approved for Care Plan
0771021292	01	04/13/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial	NPI			SN	26 Per Date Span	Auto Approved for Care Plan
0771021334	01	04/12/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial	NPI			SN	13 Per Date Span	Auto Approved for Care Plan
0771022203	01	04/10/2017	04/30/2018	04/21/2017	06:00:11	Home Care Progra	Initial	NPI	T1004			24 Per Calendar Week	Auto Approved for Care Plan
0771022209	02	04/23/2017	04/30/2018	04/26/2017	06:00:11	Home Care Progra	Initial	NPI			SN	27 Per Date Span	Auto Approved for Care Plan
0771022650	01	04/11/2017	04/30/2018	04/24/2017	06:00:10	Home Care Progra	Initial	NPI			SN	26 Per Date Span	Auto Approved for Care Plan

PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub
0771009324	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial
0771009325	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial
0771021292	01	04/13/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial
0771021334	01	04/12/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial
0771022203	01	04/10/2017	04/30/2018	04/21/2017	06:00:11	Home Care Progra	Initial
0771022209	02	04/23/2017	04/30/2018	04/26/2017	06:00:11	Home Care Progra	Initial
0771022650	01	04/11/2017	04/30/2018	04/24/2017	06:00:10	Home Care Progra	Initial

Prior Authorization

Viewing and Understanding the Prior Authorization Review

Services may be authorized by:

- Procedure Code – code authorized must be billed on the claim
- Procedure Code with modifier(s) – code and all modifiers authorized must be billed on the claim
- Procedure Code(s) List – any combination of the codes on the list may be billed up to the number of units authorized
- Procedure Code/Modifier(s) List – any combination of the codes with associated modifier(s) on the list may be billed up to the number of units authorized

39	SKILLED SERVICES BY REGISTERED NURSE (RN) FOR MANAGEMENT AND EVALUATION OF A PLAN OF CARE G0162 G0162 TT
----	--

NOTE: Discrepancies should be reported to the Access/ case Management Agency

Prior Authorization

PA details

Authorized services are for a Nursing Aide Service one time only service to a subsequent client with billing codes **T1004 U2 TT** for **12 units = 3 hours** of authorized service with an **effective/end date of 12/1/19** and **frequency of 12 units per calendar week**.

Line Item															
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	NDC	Revenue Code	Revenue Code List
01	12.000	\$0.00	12.000	\$0.00	Auto Approved for Care Plan	T1004	U2	TT							

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code **T1004** [Search] Nsg aide service up to 15min

Mod 1 **U2** [Search]

Mod 2 **TT** [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List [Search]

Requested Eff./End Dates* **2/1/2019** **2/1/2019**

Requested Units/Dollars* 12.000 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Authorized Units/Dollars 12.000 \$0.00

Authorized Eff./End Dates **2/1/2019** **2/1/2019**

Used Units/Dollars 0 \$0.00

Available Units/Dollars 12 \$0.00

Frequency **12 Per Calendar Week**

NDC [Search]

Status Auto Approved for Cari

Prior Authorization

PA Details

This PA for Skilled Nursing services is authorized with a **Procedure Code/Modifier list SN**.

The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

Line Item															
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	NDC	Revenue Code	Revenue Code List
01	15.000	\$0.00	15.000	\$0.00	Approved							SN			

Type changes below.

Line Item 01

Service Type Code* Procedure/Mod List ▾

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List SN Skilled Nursing

Procedure Code List

Requested Eff./End Dates* 12/01/2019 12/15/2019

Requested Units/Dollars* 15.000 \$0.00

NDC [Search]

Status Approved

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates 12/01/2019 12/15/2019

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

Prior Authorization

PA Modifiers

Modifiers include:

U2 - One Time Only Services can be used to authorize:

- Additional units needed on a day service is provided
- Another day of service in an existing care plan
- An additional frequency to an existing service

The screenshot shows a software interface for entering service details. It includes a 'Line Item' field with the value '01'. Below it is a 'Service Type Code*' dropdown menu currently set to 'Procedure Code'. Underneath, there is a 'Procedure Code' field containing 'T1004' and a search button labeled '[Search]'. To the right of the search button is a text box containing 'Nsg aide service up to 15min'. Below the procedure code field, there are two modifier fields: 'Mod 1' containing 'U2' and 'Mod 2' containing 'TT'. Both 'U2' and 'TT' are highlighted with green boxes. A large green arrow points from the right towards the 'U2' modifier field.

Prior Authorization

PA Modifiers

TT - Subsequent Client can be used to authorize:

- Service for an additional client residing in the home of a client already receiving the same service.
- No procedure code restrictions

If authorized:

- The **TT** modifier must be associated to the procedure code on the care plan/PA

Line Item 01

Service Type Code* Procedure Code

Procedure Code T1004 [Search] Nsg aide service up to 15min

Mod 1 U2 [Search]

Mod 2 TT

Prior Authorization

PA Modifiers

TG – Complex Visit can be used to authorize:

- Complex nursing care greater than two (2) hours of nursing care per day
- Is billed in conjunction with PA from CHNCT
- Billed for services S9123 – Nursing care in home by Registered Nurse, per hour and S9124 - Nursing care in home by licensed practical nurse, per hour

If authorized:

- The **TG** modifier must be associated to the procedure code on the PA
- If used when billing S9124, must also bill with modifier **TE** - LPN/ LVN for complex/high tech level of care services rendered by a licensed practical nurse

For more information see Provider Bulletin 17-60

Claims Processing

Claim Processing – 3 Week Cycle

Providers should remember that because payment for services rendered are made twice per month there are several times per year when providers encounter a 3 week cycle. Providers are strongly encouraged to submit enough claims prior to the 3 week cycle to meet their organizations/ agency’s operational needs.

A 3 week cycle is indicated on the “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule” with the following identifier “-b” under Claim Cycle Date.

To download the Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule navigate to www.ctdssmap.com, select Information> Publications> in the title field enter “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule”.

2020 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Check Mail Dates	EFT/835 Dates
Jul	10-b	9	14	15	15
	24	23	28	29	29
Aug	7	6	11	12	12
	21	20	25	26	26
Sep	4	3	9*	10*	10*
	18	17	22	23	23
Oct	9-b	8	14*	15*	15*
	23	22	27	28	28
Nov	6	5	10	12***	12***
	20	19	24	25	25
Dec	4	3	8	9	9
	18	17	22	23	23

b - Denotes 3 week cycle
c - Denotes Thursday cycle

* Denotes a 1 day delay in availability due to Monday Holiday
** Denotes a 1 day delay in availability due to Tuesday Holiday
*** Denotes a 1 day delay in availability due to Wednesday Holiday

Claims Processing/Submission Information

Claims submitted to DXC Technology are each assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research

(20)(19)(005)(123)(456)

1 2 3 4 5

- 1 Claim Region** – Identifies the manner in which the claim was submitted (**20** = *Electronic Claims with No Attachments*. The ICN Region Code List can be found on our Web site under *Information > Publications > Claims Processing Information*.)
- 2 Year of Receipt** – Indicates the year in which the claim was received by DXC Technology (**17** = 2017)
- 3 Julian Date of Receipt** – The Julian calendar date of receipt (**005** = *the fifth day of the year; January 5*)
- 4 Batch Number** – An internal number assigned by DXC Technology to uniquely identify a batch (**123**)
- 5 Claim Number** – A sequential number assigned to uniquely identify claims within a batch (**456**)

Claims Processing/Submission Information

When a claim processes through CMAP, it is subject to a series of edits that check the validity of claim data such as:

- The submitted Provider must be **actively enrolled** on the date of service.
- Client must be **eligible** on date of service.
- Procedure Code submitted must be **valid** for the Provider Type.

Each claim then passes through a series of audits.

- The claim is compared to **previously paid claims**.
 - Is the current claim a duplicate of a paid claim?
- Does the billed procedure code require PA?
- Does the billed procedure code have PA?

Claims Processing/Submission Information

Third Party Liability (TPL) Information

Commercial / private insurance coverage other than Medicare or Medicaid under which the client is be covered must be on the billed claim.

Medicaid is the payer of last resort

- Because of this providers must investigate the possibility of clients having other insurance coverage and pursue payment prior to submitting their claim to DXC Technology
- Providers can see other insurance coverage in the eligibility verification process.

Claims can potentially deny when a discrepancy in TPL data exists on the client's state profile

- A Third Party Liability Information Form should be sent to Health Management Systems (HMS)
 - This form is available on the Information > Publications page of www.ctdssmap.com
- HMS will contact the insurance carrier and notify DSS of any discrepancy to avoid having CMAP claims unnecessarily denied for health insurance or Medicare reasons.
- Client eligibility will be updated

Claims Processing/Submission Information

Third Party Liability (TPL) Information

Any TPL payers must be billed prior to submitting claims to Medicaid.

TPL claims submitted to DXC Technology with other insurance payment or denial must include:

- Carrier's unique three-digit carrier code
 - Available through eligibility verification (Web, phone, X12N 270/271 Eligibility Benefit Inquiry / Response Transaction) and in Chapter 5 of the CMAP Provider Manual

- The Amount Paid (on a paid claim) or "0.00" for a TPL denial
- The date of payment or denial from the TPL Explanation of Benefits (EOB)
 - The physical TPL EOB should not be submitted with paper claims; the provider must retain this for audit purposes
- The Subrogation Process – Available to providers who do not receive timely responses from insurance carriers to get their claim paid.
 - For more information on this please see Chapter 5 of the Provider Manual on ctdssmap.com Web site.

Claims Processing/Submission Information

Medicare Coinsurance and / or Deductible Claim Submission:

- Claims for clients covered under Medicare must first be billed to Medicare.
- Crossover claims are claims that Medicare has considered and made payment on.
- Crossover claims from Medicare will be denied if TPL information is on the client's eligibility file.
- Only claims paid by Medicare will be electronically submitted to Medicaid.
- Claims that do not cross over from Medicare or are denied by Medicare can be submitted by the provider to DXC Technology.
- Claims submitted do not need the Explanation of Medicare Benefits (EOMB) attached if Medicare denied the service. Enter Medicare N/A or Medicare HMO N/A and the date of Medicare's denial.
- TPL or Medicare Coinsurance and / or Deductible Reimbursement:
 - Medicaid **will pay** up to the Medicaid Allowed Amount minus any Medicare or TPL payment.
 - Medicaid **will not pay** if the Medicare or TPL payment is equal to or exceeds the Medicaid Allowed Amount.

A provider may not balance-bill the client, financially responsible relative, or representative of the client.

Medicare Cost Avoidance and Home Health Audit



Medicare Cost Avoidance

Home Health Agencies are required to submit claims for dually eligible clients to DXC Technology indicating the reason an Advanced Beneficiary Notification (ABN), Form CMS-R-131 was issued to the client.

Claim Submission:

Claims for dually eligible clients who are traditional or Medicare Managed Care (A, B or A&B benefit eligible) and HUSKY eligible, must contain:

- ❑ At least one HIPAA Adjustment Reason Code (**150, 151, or 152**)
- ❑ Date the associated ABN or MCO Notice of Medicare Non-Coverage (NOMNC) was issued.
- ❑ The **issue date** of the ABN must be within **one year of the date of service**.

Note: This is not applicable to Medicare clients who are State Funded CT Home Care eligible.



Medicare Cost Avoidance

Claim Denial:

If a client's care does not meet Medicare's coverage criteria and the claim does not contain one of the indicated Adjustment Reason Codes and corresponding ABN issue date, the claim will deny **Explanation of Benefit Code (EOB) code 2522 - "Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of ABN or NOMNC"**.

Claim Auditing:

- Claims submitted with a HIPAA Adjustment Reason Code 150, 151, or 152 will be included in an Other Insurance Audit based upon a random sample of claims that contain one of the three Adjustment Reason Codes.
- Audited Home Health providers will be required to submit a copy of the original signed and dated ABN associated with the selected claim under review.



Medicare Cost Avoidance

Claim Auditing cont.

- Failure to provide the appropriate ABN issued contemporaneously with the date of the selected claim will result in the claim being recouped.
- Providing an ABN with a different signature date than the ABN date of issue indicated on the claim will also result in recoupment of the claim.

Medicare Cost Avoidance

These codes can only be used for Medicare as a third party payer.

These codes are not valid for any other third party payer.

Home Health Agency Reasons to Issue Advanced Beneficiary Notice	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Code Description
Client determined to be not homebound; either at the start of care or after Medicare-covered services has been provided.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client receiving thirty-five (35) hours per week of Medicare-covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week.	151	Payment adjusted because the payer deems the information submitted does not support this many services.
Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g. nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client's continued care determined to not be Medicare-coverable. CMS required Annual HHABN issued.	152	Payment adjusted because the payer deems the information submitted does not support this length of service.

Claims Audit Criteria

In accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, audit protocols have been published on the Department of Social Services' Web site. An introduction to audit protocols and an overview of the audit process can be found at: <http://www.ct.gov/dss/auditprotocols>. Additional resources can be found in provider bulletin 17-29.

Links to audit protocols organized by provider type are located on the lower section of this Web page.

[Alcohol and drug abuse centers audit protocols](#) 


[Birth to Three Audit Protocol](#) 

[Dental audit protocols](#) 

[Department of Developmental Services Waiver audit protocols](#) 

[Homecare audit protocols](#) 

[Home health audit protocols](#) 

[Medical equipment audit protocols](#) 

[Outpatient hospital audit protocols](#) 

[Pharmacy audit protocols](#) 

[Physicians audit protocols](#) 

[Transportation audit protocols](#) 

[Long Term Care Audit Process](#) 

Claims Audit Criteria

Home Health audit protocols list the most common reasons why a provider's claims may be audited. You can find the Audit Protocols at www.ct.gov/dss > Organization Structure - Divisions> The Office of Quality Assurance > Related Resources> Audit Protocols> Home Health audit protocols.

DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL - HOME HEALTH SERVICES
UPDATED MAY 1, 2017

Listed are the most common audit findings for Medicaid home health services, and clarification of the criteria the Connecticut Department of Social Services (the "Department") uses when it makes those findings. Disallowances for home health services under the Medicaid program are governed by policies included in the Connecticut Medical Assistance Program Provider Manual (PM), the Medicaid Provider Enrollment Agreement (PA), Provider Bulletins (PB), the Regulations of Connecticut State Agencies (Conn. Agencies Regs.), the Connecticut General Statutes (Conn. Gen. Stat.) and the Code of Federal Regulations (C.F.R.). This protocol is for services performed prior to the implementation of the Electronic Visit Verification system. Please see the protocol for homecare services for additional requirements that may apply to home health services.

Title	Audit Criteria	Regulatory Reference
Billing - Failure to Utilize Third Party Liability.	The Department will disallow payment for services if there is a private insurance/third-party payor that the provider failed to bill first or did not receive a denial of payment by the third party.	Conn. Agencies Regs. § 17b-262-526(3)

Claim Denial and Corrective Action

Claim Denial and Corrective Action

Claim Denials, Resolution and Resources

Claim Denials due to Client Eligibility

Denial Reasons:

- EOB Code 2003** - Client Ineligible for dates of service
- EOB Code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan.

If EOB code 4021 is the only EOB that sets on the claim, the client does not have Husky, or an Autism, ABI, CHC or PCA waiver benefit plan. If any other EOB is on the claim, action should be taken on the other EOB code and disregard EOB code 4021.

Resolution:

- If the client does not have an ABI, CHC, PCA or Autism waiver benefit plan, the client or their representative should contact the DSS Benefits Center for assistance with the client's eligibility. If the client has the ABI, CHC, PCA or Autism waiver then the client eligibility file needs to be updated with the appropriate benefit plan or change made to the effective dates of eligibility.

Claim Submission

Claim Denials, Resolution and Resources

Claim Denials due to Client Eligibility (continued) - Resources:

- ❑ Providers should first verify with the care manager at the Access/Case Management Agency or DSS Autism Case Manager responsible for the client's care plan that the client's Medicaid redetermination and financial verifications have been submitted to DSS for processing.
- ❑ If the clients Medicaid redetermination and financial verifications have been submitted to DSS and the access agency cannot be of further support, the Community Options Unit, formerly the Alternate Care Unit, at DSS should be notified of the eligibility issue. Providers should send an encrypted email to Waiver.DSS@ct.gov
- ❑ The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "<Waiver> Client Eligibility Issue" in the subject line of the email

To avoid claim denials due to eligibility, providers should verify client eligibility prior to performing a service.



Claims Submission

Claim Denials, Resolution and Resources

Claim Denials Related to Care Plan/PA Issues

Denial Reasons:

EOB Code 3015 –Care Plan Required

- **Resolution:** A care plan must be created by the Access Agency (CHC or PCA Waiver), Case Management Agency (ABI Waiver) or DSS Autism Case Manager via batch uploaded or interactive entry via a secure Web account to the claims processing system.

EOB Code 3016 - Service not Covered Under Care Plan

Resolution: A service denied for not on care plan must be added by the Access/Case Management Agency or DSS Autism Case Manager to the Care plan.

Please note: Neither DSS nor DXC can enter or correct care plans or PAs. If a care plan or PA needs to be entered or corrected providers need to contact the Access/Case Management Agency or DSS Autism Case Manager responsible for the clients care plan for assistance.



Claims Submission

Claim Denials, Resolution and Resources

Claim Denials related to Care Plan/PA Issues (continued) - Denial Reasons

- **EOB Code 5151** - Units exceed frequency units on care plan.

Resolution: Units of service must be added to the frequency of an existing PA by the Access/Case Management Agency or DSS Autism Case Manager.

- **EOB Code 3003** -Prior Authorization is required for payment of the service (units for the service are exhausted)

Resolution: Units of service must be added by the Access/Case Management Agency or DSS Autism Case Manager to an existing PA that is currently exhausted.

Claims Submission

Claim Denials, Resolution and Resources

Claim Denials related to Care Plan/PA Issues (continued) - Resources:

- Case Managers create service orders and enter them in the Access/Case Management Agencies Care Management System.

- The Access/Case Management Agency is responsible for uploading initial care plans and changes to care plans to DXC Technology, in Prior Authorization format, within seven (7) days of issuing the service order. DSS Autism Case Managers enter care plans and changes via a secure Web account directly into the PA subsystem for claims processing.

- If the provider has a service order and a PA for the service order cannot be found by doing a PA inquiry via the provider's secure Web account within seven (7) days of receipt of the service order, the provider should contact the applicable Access/ Case Management Agency or DSS Autism Case Manager.

For assistance in resolving claim denials, please refer to Provider Manual chapter 12 – Claim Resolution Guide.



Claims Submission

EVV Claim Denials, Resolution and Resources

Claim Denials related to EVV mandated claims submitted outside of the Santrax system:

EOB code 3327 - Confirmed visit not found

This EOB posts to a claim containing an EVV mandated service if there is no confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s).

Resolution: the visit must be confirmed in the provider's Santrax system.

NOTE: Confirmed visit data used in claims processing may take up to 24 hours for access to systematic confirmation therefore, visits must be confirmed at least 24 hours prior to claim submission.

EOB code 3328 - Confirmed visit units are exhausted

This EOB posts to a claim containing an EVV mandated service where there is a confirmed visit that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units have been exhausted due to a previously submitted and paid claim.

Resolution: Increase the units on the confirmed visit in Santrax.

Electronic Visit Verification (EVV) – 2018 Update

EVV Claim Denials, Resolution and Resources

Claim Denials related to EVV mandated claims submitted outside of the Santrax system cont'd:

- ❑ **EOB code 0047** - Confirmed visit units are exceeded

This EOB posts to a claim containing an EVV mandated service where there is a confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s), however, *the visit units on the confirmed visit are less than the units billed on the claim*. This claim will pay, but it will cut back to the number of units on the confirmed visit.

Resolution: increase the units on the confirmed visit.

Please note: EOB code 0047 may also occur if there are two visits for the same client and service on the same day and only one visit is confirmed. The second visit must be confirmed in order for the claim to pay the total number of units billed for the day.

- ❑ **EOB code 3329** - Details cannot exceed 31 days

This EOB posts on claims submitted from Santrax are limited to one date of service per claim detail. Claims submitted outside of Santrax may be submitted using spanned dates. These spanned dates cannot exceed the lessor of 31 days or a single month of service.

Resolution: reduce the number of days submitted on the claim detail.

Monthly Claims Reprocessing

Monthly Claims Reprocessing

The Access or Case Management Agencies are allowed to make retroactive changes to Care Plans even when claims are paid against the Prior Authorization (PA) for a CHC, Autism waiver, PCA or ABI Waiver client.

- ❑ Access and Case Management Agencies can make changes to individual care plans without requesting the provider recoup/void claims paid for dates of service on or after the effective date of the change.

A Systematic Monthly Claims Reprocessing for all ABI, Autism, CHC and PCA claims occurs in the first financial cycle of each month to:

- ❑ Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Access or Case Management Agencies.

Monthly Claims Reprocessing

Systematic Monthly Reprocessing

- ❑ In the first cycle of each month, DXC Technology will recoup (void) all paid claims impacted by the Access or Case Management Agency PA changes made two months prior. (*A claim that starts with Region code 52 is a voided claim*).

- ❑ In the same cycle DXC Technology will reprocess to, deny and/or pay claims posting to the correct PA/PA line detail. (*A claim that starts with Region code 24 is a new day claim*).

- ❑ There is a two month delay between the PA change and reprocessing of the claim impacted by the change.
 - ❑ For example: In the first cycle of June claims impacted by changes made in April will be reprocessed.

Note: *Region = the first two digits of the claim Internal Control Number (ICN).*

Monthly Claim Reprocessing

Impact to Provider Remittance Advice (RA)

- If there is a financial impact (change in reimbursement amount up or down) between the voided claim (**region 52**) and the reprocessed claim (**region 24**):

Providers will see in the adjustment section of their RA:

- The previously paid claim ICN (**Region 20, 22, 59, 10** etc.)
- Recouped/Voided claim ICN (**Region 52**)
- EOB Code 8236** – Claim was recouped due to PA change

Monthly Claims Reprocessing

REPORT: CRA-HHAD-R
RA#: 7181817

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PROVIDER REMITTANCE ADVISE

Date: 04/09/2019
PAGE: 107

HOME HEALTH CLAIM ADJUSTMENTS

Health Service Provider
1243 Main Street
Hartford, CT 06106

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

MCD 001234567
04/09/2019
251E00000X
001234567

FP	--ICN--	ATTEND PROV.	SERVICE DATES	BILLED	ALLOWED	TPL	CO-PAY	PATIENT	PAID
	--PATIENT NUMBER--		FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	LIABILTY	AMOUNT
1	5919094008990	NPI 1255772307	091418 092118	259.00	0.00	0.00	0.00	0.00	0.00
	00205243								
REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	ALLOWED AMT	DETAIL	E0BS	
580	T1001	091418		1.00	148.00	0.00	2522 4021 4227	4980	
580	G0162	092118		3.00	111.00	0.00	2522 4021 4227	4980	
CLIENT NAME: SHIRLEY			CLIENT NO.: 001234567						
1	221900000000	NPI 1114085016	082718 082718	(148.00)	(95.20)	(0.00)	(0.00)	(0.00)	(95.20)
	00001897								
1	522000000000	NPI 1114085016	082718 082718	148.00	0.00	0.00	0.00	0.00	0.00
	00001897								
HEADER E0BS: 8236									

Monthly Claims Reprocessing

Impact to Provider Remittance Advice (Paper RA)

A new claim will be systematically created. Providers will see the new day claim on their RA.

Claim ICN (**Region 24**) in the paid/denied section of the RA.

EOB Code 8238 – Claim Systematically Reprocessed Due to a PA/Service Order Change.

NOTE: If the reprocessed region 24 claim pays the same as the recouped region 52 claim, neither claim will appear on the paper RA.

Monthly Claims Reprocessing

Monthly Claim Reprocessing Due to PA Changes

Claim Reprocessed and appears on RA (paid amount region 24 claim greater than amount recouped – region 52 claim)

REPORT: CRA-HHPD-R
RA#:

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PROVIDER REMITTANCE ADVICE
HOME HEALTH CLAIMS PAID

Date:
PAGE: 2

Home Health Agency
555 Any ST
Somewhere, CT 00000-0000

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI

251E00000X

FP	--ICN--	ATTEND PROV.	SERVICE DATES	BILLED	ALLOWED	TPL	CO-PAY	PATIENT	PAID
	--PATIENT NUMBER--		FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	LIABILTY	AMOUNT

Sally Client			CLIENT NO.:	000000000					
2400000000000	NPI		071517 072217	600.00	396.94	0.00	0.00	0.00	396.94

REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED ANT	ALLOWED ANT	DETAIL	EOBS
580	S9124	071517		1.00	175.00	114.74	8238	
570	T1004	071517		6.00	75.00	48.54	8238	
580	S9123	071817		1.00	175.00	116.83	8238	
580	S9123	072217		1.00	175.00	116.83	8238	

Monthly Claims Reprocessing

Monthly Claims Reprocessing Due to PA Changes

Impact to Provider's Secure Web Portal – Claim Inquiry

Regardless of the financial impact (more, less or no \$ change):

- All **region 52** and **region 24** claims will appear on the provider's secure web account when performing a claim inquiry.

Region 24 claims with no financial impact (i.e. region 24 claims paid the same as voided region 52 claims) **will appear on the web only** with:

- EOB code 8237** – Claim Systematically Reprocessed Due to Retro Change-Information Only.

Note: These claims will not appear on the provider's RA

Monthly Claims Reprocessing

Monthly Claims Reprocessing Due to PA Changes

Impact to PA Inquiry in Provider's Secure Web Portal

- Region **24 claims** identify a change made to the care plan/PA.

- Region **24 claims** with **EOB Code 8238** – “Claim Systematically Reprocessed Due to a PA/Service Order Change” confirms there has been a change which has:
 - Positively or negatively impacted you financially.
 - May impact you financially in the future.

- Providers should investigate reprocessed claims with a **negative** impact to determine if:
 - Providing appropriate level of service currently authorized.
 - Current service order matches the PA on their secure Web account.
 - Report discrepancies to the Access/Case Management Agency or DSS Autism Case Manager.

Monthly Claims Reprocessing

Monthly Claims Reprocessing Due to PA Changes

Impact to Provider's Secure Web Portal – PA Inquiry (continued)

A PA may show negative units available, if the changes made by the Access Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.

For example:

- PA authorized for 4 units per week for 4 weeks = 16 units authorized and available.
- Claims are paid against the PA = 16 units used
- Access Agency changes the PA to 4 units a week for 3 weeks = 12 units authorized due to hospitalization after the third week

Until claims are recouped and reprocessed, the PA will show 12 units authorized – 16 used = (4) negative (available) units.

Remittance Advice (RA)



Remittance Advice

Financial Transaction:

In a scenario where a claim denies with the Explanation of Benefits (EOB) **code 2003 “Client ineligible for dates of service”** even though you have an eligibility verification response that the client was eligible for the date of service, you can submit an appeal to DXC Technology’s Written Correspondence Unit at the following address:

DXC Technology
PO Box 2991
Hartford, CT 06102

The appeal should be on the provider’s letterhead and include the Eligibility Verification Number and a paper claim for the services rendered that were denied.

Remittance Advice

Financial Transaction:

DSS will issue a **Financial Payout** for the services rendered in lieu of the claim.

- ❑ You will see the payout information in the **Financial Transactions** section of your Remittance Advice as a “Non-Claim Specific Payout.”
- ❑ The Liability Date refers to the date of service for the claim that was denied due to the client being ineligible.

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PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

Date: 02/07/2017
PAGE: 51

-----NON-CLAIM SPECIFIC PAYOUTS-----

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
151250000		394.16	8306	0099999999	BABYC CAREY	11/02/2016
TOTAL PAYOUTS:		394.16				

Information/ Resources

Information/ Resources

Important Messages

www.ctdssmap.com contains a wealth of information for providers:

Important Messages

Available on the Home page and on the Information page

Contains urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes. Reference the COVID-19 IM for FAQs, Bulletins and IMs with important DSS communications during the Emergency period.



Information

Important Messages

[Attention Providers: Provider Bulletin 2020-63 Clarification \(Posted 8/27/20\)](#)

[COVID-19 Information and FAQs \(Updated 8/13/20\)](#)

[Hospital Monthly Important Message \(Posted 8/11/20\)](#)

[Attention Home and Community-Based Waiver Providers and Access Agencies: Rate Methodology and Cost Survey \(Posted 7/29/20\)](#)

[Attention EVV Service Providers: Introducing the Sandata Mobile Connect \(SMC\) App \(Updated 7/24/20\)](#)

Information/ Resources

RA Banner Announcements

Available by selecting Information >Messages Archive or clicking on RA Banner Announcements in the Information box on the left side of the home page.

Messages originally published for providers on the first page of their remittance advice. Some banner announcements are provider specific and therefore are only sent to the relevant provider types/specialties.

Often published in reference to reprocessed claims; explaining the reasons behind the reprocessing as well as the claim types affected.

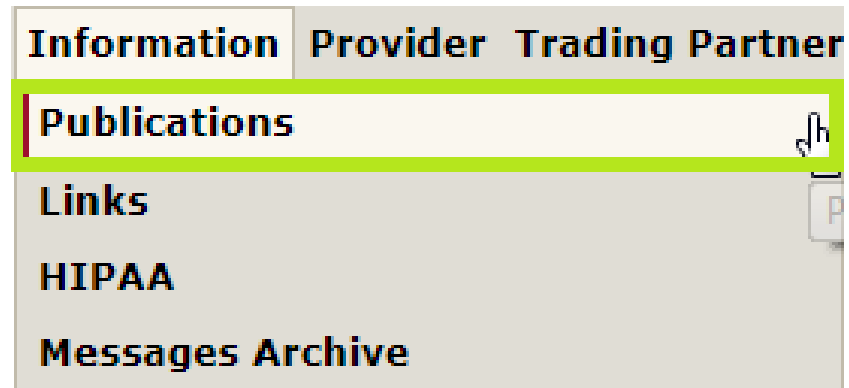
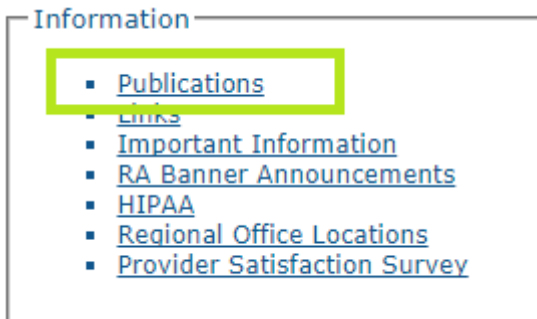
06/05/2020-06/10/2020	Attention Select Home Health Providers	Attention Select Home Health Providers. RECOUPMENT TRANSACTIONS: The Department of Social Services (DSS) has completed a Centers for Medicare & Medicaid Services (CMS) financial transaction settlement in the June 5, 2020 claims cycle. The recoupments are related to a Home Health settlement with CMS and will appear on your June 9, 2020 Remittance Advice (RA) under Accounts Receivable with reason code 8407 "CMS Settlement".
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Information/ Resources

Publications

A majority of the information available on the www.ctdssmap.com Web site is located on the Publications page

Access the Publications page by selecting Publications from either the Information box on the left side of the home page or from the Information drop-down menu.



Information/ Resources

Provider Bulletins

Publications posted to relevant provider types / specialties documenting changes or updates to the CT Medical Assistance Program

Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.

Bulletin Search

Year

Provider Type

Number

Title

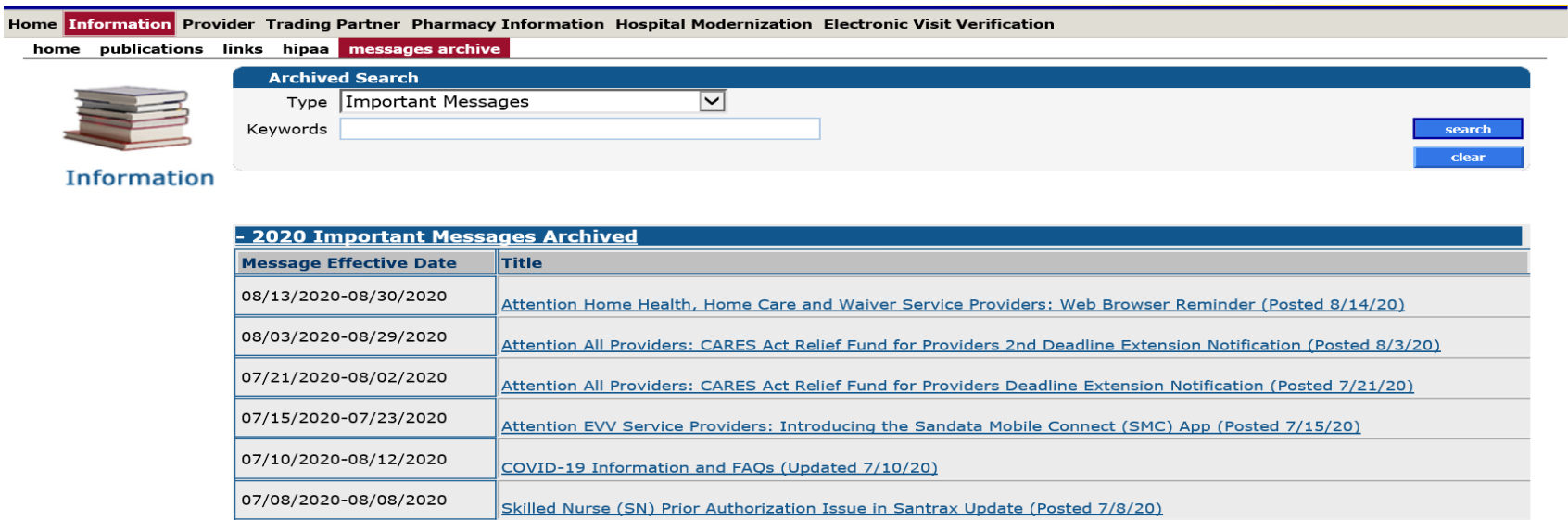
Search Results		
Bulletin Number	Title	Published Date
PB20-53	CMAP COVID-19 Response - Bulletin 37: Reauthorizations of Home Health Services D...	05/29/2020
PB20-51	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/27/2020
PB20-48	REVISED CMAP COVID-19 Response - Bulletin 32: Services Covered Under the Optiona...	05/15/2020
PB20-45	CMAP COVID-19 Response - Bulletin 29: Updated Guidance Regarding Audio-Only Tel...	05/11/2020
PB20-44	CMAP COVID-19 Response - Bulletin 30: Updated Audio-Only Behavioral Health (Tele...	05/11/2020
PB20-43	CMAP COVID-19 Response - Bulletin 28: Emergency Medicaid for Non-Citizens	04/30/2020
PB20-42	CMAP COVID-19 Response - Bulletin 27: New COVID-19 Coverage Group for Uninsured ...	04/30/2020
PB20-39	CMAP COVID-19 Response - Bulletin 25: Non-Emergency Medical Transportation and N...	04/13/2020
PB20-38	CMAP COVID-19 Response - Bulletin 26: Additional Changes to the Synchronized Tel...	04/16/2020
PB20-34	CMAP COVID-19 Response - Bulletin 21: Select Added Services to the Emergency Tem...	05/11/2020
PB20-33	CMAP COVID-19 Response - Bulletin 23: Changes to the Prior Authorization Require...	04/13/2020
PB20-28	CMAP COVID-19 Response - Bulletin 13: Emergency Temporary Telemedicine Coverage/...	04/01/2020
PB20-27	CMAP COVID-19 Response - Bulletin 12: Waiver of Certain Requirements and Tempora...	03/27/2020
PB20-15	CMAP COVID-19 Response - Bulletin 5: Elimination of Copayments for Services Rend...	03/18/2020
PB20-14	CMAP COVID-19 Response - Bulletin 4: Expanded Telemedicine and New Audio-Only (T...	03/19/2020
PB20-11	Accessing the Provider's Re-enrollment Due Date	03/16/2020
PB20-10	CMAP COVID-19 Response - Bulletin 1: Emergency Temporary Telemedicine Coverage	03/11/2020
PB20-09	New Coverage of Specified Telemedicine Services Under the Connecticut Medical As...	03/11/2020

Information/ Resources

Archive Important Messages and Banner Announcements


Important Messages and RA Banner Announcements are available on the Home page of the www.ctdssmap.com Web site. Only the most current messages will be posted in the main areas on the Web for a limited time; thereafter, providers will be able to retrieve previously published Important Messages and Banner Announcements from messages archive. To access the messages archive page, select messages archive from the Information drop-down menu on the home page.

RA Banner Announcements and Important Messages dated January 1, 2014 and forward are saved on the Web site and are available for review.



Home **Information** Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification

home publications links hipaa **messages archive**


Information

Archived Search

Type:
Keywords:

- 2020 Important Messages Archived

Message Effective Date	Title
08/13/2020-08/30/2020	Attention Home Health, Home Care and Waiver Service Providers: Web Browser Reminder (Posted 8/14/20)
08/03/2020-08/29/2020	Attention All Providers: CARES Act Relief Fund for Providers 2nd Deadline Extension Notification (Posted 8/3/20)
07/21/2020-08/02/2020	Attention All Providers: CARES Act Relief Fund for Providers Deadline Extension Notification (Posted 7/21/20)
07/15/2020-07/23/2020	Attention EVV Service Providers: Introducing the Sandata Mobile Connect (SMC) App (Posted 7/15/20)
07/10/2020-08/12/2020	COVID-19 Information and FAQs (Updated 7/10/20)
07/08/2020-08/08/2020	Skilled Nurse (SN) Prior Authorization Issue in Santrax Update (Posted 7/8/20)

Information/ Resources

E-mail Subscriptions

Register for E-mail Subscriptions

Providers **MUST** register to receive information electronically for new provider publications and notifications through the email subscription function on the CMAP Web site at www.ctdssmap.com. Communications are no longer mailed to providers and must be downloaded from the DSS Web site.

- *For complete E-mail subscription information, please see Provider Bulletin PB15-23 on the CMAP Web site

E-Mail Subscriptions

Do you want to get the latest information from the Connecticut Medical Assistance Program (CMAP)? Registration is a very quick and simple process! You can register now to receive on-line publications such as provider bulletins, workshop invitations, newsletters, and important messages via email by entering your email address below under "New Subscriber". Once you have entered your email address and confirmed that address, you will be asked to select the type of information you wish to receive (reference list of provider types, trading partner, and topics on the right side of the screen). Once registered, you will receive a confirmation email.

There is no limit on the number of e-mail subscriptions per office! Each provider, member of your office staff, enrollment support staff, etc. can subscribe to receive information via email.

It is important to note that, as of June 30, 2015, the Department of Social Services will no longer send provider bulletins and workshop invitations via the postal service. To ensure that you receive the latest information from CMAP, you must either subscribe to receive this information or review the information posted to www.ctdssmap.com daily to obtain newly published information.

Once you have subscribed, you can modify the type of information you receive at any time by entering your email in the Existing Subscribers box below. You may also unsubscribe at any point in time by entering your email in the Unsubscribe box below.

Subscribe, modify an existing subscription, or unsubscribe.

New Subscriber

E-Mail

Confirm E-Mail

Existing Subscribers

E-Mail

Unsubscribe

E-Mail

Available Subscriptions

- **Provider**
- ALL Provider Types
- Acquired Brain Injury
- Advance Practice Nurse
- Autism Spectrum Disorder/Behavior Analysts
- Autism Waiver
- BHH/TCM/Waiver Provider
- Behavioral Health Clinician
- Birth to Three
- CHC Access Agency
- CHC Assisted Living
- CHC PCA Fiduciary
- CHC Service Providers
- Certified Nurse Midwife
- Chiropractor
- Clinic
- Clinic EPSDT
- Community First Choice
- Community Services
- DDS Employment and Day Supports
- DDS Specialized Services
- DME/Medical Supply Dealer
- Dental
- Drug and Alcohol Abuse Center
- Early Childhood Autism Waiver
- Extended Care Facility/Long Term Care
- FQHC - Behavioral Health
- FQHC - Dental
- FQHC - Medical & Tribal Svs Medical
- Home Health Agency
- Hospice Agency
- Hospital
- Laboratory
- Local Health Department
- Mental Health Group Home
- Mental Health Waiver
- Naturopath



Information/ Resources

Provider Manual

Access via the www.ctdssmap.com Web site Home page >Information > Resources > Provider Manuals

The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission

It is the primary source of information for submitting CMAP claims, prior authorizations, and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions

The Provider Manual is divided into twelve (12) chapters

Click on the chapter title to open the document (*disable* pop-up blockers)

Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter

Chapter 11 is claim-type specific



Information/ Resources

Provider Manual

Chapter 1 – Introduction

Provides information on the CT Medical Assistance Program, the Department of Social Services' and DXC Technology's responsibilities and resources

Chapter 2 – Provider Participation Regulations

Details the CMAP regulations for provider participation

Chapter 3 – Provider Enrollment

Provides information on provider eligibility in reference to provider enrollment and re-enrollment

Chapter 4 – Client Eligibility

Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability

Chapter 5 – Claim Submission Information

Provides information on general claims processing and billing requirements

Chapter 6 – EDI Options

Provides information on electronic claim submission and electronic RAs



Information/ Resources

Provider Manual cont'd

Chapter 7 – Regulations/Program Policy

This section contains the Medical Services Policy sections that pertain to the chosen provider type

Chapter 8 – Billing Instructions

Provides information on provider specific billing requirements and instructions

Chapter 9 – Prior Authorization

Provides information on how to obtain Prior Authorization for designated services

Chapter 10 – Web Portal/Automated Voice Response System (AVRS)

Provides information on both the AVRS and the Web Portal functions

Chapter 11 – Other Insurance/Medicare Billing Guides

Provides claim-type specific information on other insurance and Medicare billing

Chapter 12 – Claim Resolution Guide

Provides descriptions of common EOBs and, if applicable, information to resolve the errors

Information/ Resources

Provider Newsletters

Quarterly publications to providers on a wide range of topics

Provider Newsletters

- [August 2020 interChange Newsletter](#)
- [April 2020 interChange Newsletter](#)
- [December 2019 interChange Newsletter](#)
- [November 2019 interChange Newsletter](#)
- [Provider Newsletter Archives](#)

Claims Processing Information

- Guides and FAQs to assist with billing/claims processing

Claims Processing Information

- [Eligibility Response Quick Reference Guide](#)
- [Internet Claims Submission FAQ](#)
- [Hospice Procedure Code Exception List](#)
- [ICD-10 Diagnosis Codes Not Allowed as Primary Diagnosis](#)
- [ICN Region Code List](#)
- [CT Medical Assistance Program EOB Crosswalk - Pharmacy and Non-Pharmacy](#)
- [Medically Unlikely Edit \(MUE\) Updates](#)
- [OPR Enrollment FAQ](#)

Contacts



Contacts

DXC Technology Provider Assistance Center (PAC)

- 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
- www.ctdssmap.com
- ctdssmap-ProviderEmail@dxc.com

This should be your first call resource to answer all **enrollment, eligibility** and **billing** related questions. Should your issue require a higher level of research, it will be escalated to your provider representative. Please be sure to ask the PAC representative for your call tracking number for future call reference.

DXC Technology Electronic Data Interchange (EDI) Help Desk

- 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

Contacts

EVV Email Mailbox

- ❑ ctevv@dxc.com.

If you are:

- ❑ missing a client from your Santrax system and have verified that the client is eligible on their waiver benefit plan and has a valid PA;
- ❑ or if a prior authorization (PA) is present on the www.ctdssmap.com portal but is not present in the Santrax system. **NOTE: it can take up to 48 hours before a PA that is present on the www.ctdssmap.com portal is present in Santrax.**

then contact the EVV email box for assistance.

Sandata Customer Care

- ❑ 1-855-399-8050 or ctcustomer care@sandata.com

If you are experiencing issues with the **Santrax system or its functionality** please contact Sandata Customer Care for assistance.

If you are unsure who to contact for assistance, please send an e-mail to ctevv@dxc.com.

- ❑ You are also encouraged to send an e-mail to the ctevv@dxc.com mailbox if you feel you need additional support resolving your issue. Please be sure to include your Sandata ticket number if applicable.

Contacts

Access Agencies

Connecticut Community Care (CCCI) - ServiceAuthIssues@ctcommunitycare.org

- Providers must include the following information when submitting service authorization issues to CCCI: provider name, client name, client Medicaid ID number, CCCI number, EOB code on rejecting claim at DXC Technology, from and to dates of service, the type of service (SNV, Med Admin, etc.), the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available and any comments the provider wishes to communicate to CCCI.

South Western Connecticut Area on Aging (SWCAA) - SWCAABillings@swcaa.org

- Please have the following information available when contacting SWCAA:
Client name, the client Medicaid ID number, the type of service (SNV, Med Admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Agency on Aging of South Central CT (AOASCC) - chcbilling@aoascc.org

- Companies without secure e-mail, please fax service order inquiries to (203) 528-0455. All other provider information may be faxed to (203)752-3064. Due to the high volume of inquiries AOASCC requests your primary source of communication to them be by e-mail or fax. Service Order inquiries must include, on an Excel spreadsheet, the applicable following information when contacting AASCC: client name, EMS#, type of service (procedure code), dates of service (from/to), frequency of service and the number of units or hours per visit.

Contacts

Access Agencies continued

Western Connecticut Area on Aging (WCAA)- contact WCAA directly at (203)465-1000

- Please have the following information available when contacting WCAA: client name, the client Medicaid ID number, the type of service (SNV, Med admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Department of Social Services (DSS) – For Self Directed clients on the CHCPE Program, please contact Melva Cooper, RN directly via e-mail at melva.cooper@ct.gov or by phone at (860)424-5863.

Community Option Unit at DSS- For assistance in correcting a waiver client's eligibility file, please send an email to Waiver.DSS@ct.gov



Contacts

Administrative Service Organizations (ASOs)

Community Health Network of CT CHNCT (PAs for non-waiver clients)

☐ 1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)

☐ www.ct.gov/husky

Beacon Health Options CT (PAs for clients with behavioral health primary diagnosis)

☐ 1-877-552-8247 – Monday through Friday, 9 a.m. to 5 p.m. (EST)

☐ www.CTBHP.com



Questions?



Thank you.

Thank You for attending the Connecticut Medical Assistance Program Home Health Agency 2020 Refresher Workshop!

All questions and comments regarding this training are welcome.

Please fill out the provided workshop survey.

Your feedback helps us to improve future workshops!